

## **Module II: The Role of Culture, Poverty, Race, and Economic Development on Environmental Health**

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### **Competency Statement**

The learner will obtain knowledge of the social and cultural influences of the Mississippi Delta Region (MDR). The social networks and influences of community beliefs will be highlighted. The various beliefs that have relevance for the health of clients (individuals, families, groups, and communities) will be explored. Consideration will also be given to the identification of social and economic factors, such as industrialization, which can place a community at risk. Finally the impact of religion, income, education, housing, and employment on environmental health will be reviewed.

### **Rationale**

A study of social and cultural influences in the MDR will help the student better understand residents' views of health, environmental risks, or life satisfactions and challenges, thereby facilitating health promotion initiatives for environmental health. Such a study provides a context through which nurses may implement strategies with residents that are culturally and ethnically sensitive.

Nursing environmental health competencies as outlined by Pope et al (1995) in Nursing, Health & the Environment include working with individuals, groups and communities in environmental health assessment, risk communication, intervention, and advocacy. This module supports learners' development of such environmental health competencies.

### **Objectives**

Upon the completion of this module, the student will be able to:

1. Discuss the concepts of culture and ethnicity.
2. Describe major cultural influences in the MDR.
3. Recognize the relationship between poverty and race in the MDR.
4. Determine the impact of economic development on the environment and health in the MDR.

### **Vocabulary**

Consanguineal relationships  
Culture  
Race  
Ethnicity  
Ethnography  
Cultural assessment  
Racism  
Precursor

### **Course Content**

#### **1.1 Define culture**

Culture is the acquired knowledge of a group of people that is used to interpret experience and generate behavior (Spradley, 1979). It is a way of seeing, behaving in, and evaluating one's world, thus shaping values, beliefs, and practices (Andrews & Bolin, 1993). Culture develops, is sustained or modified, out of the social interaction with one's affinity group on the basis of the meanings things have for that group. Cultural beliefs and characteristics are

acquired early in life and are not easily changed for an individual, yet the beliefs and social interactions evolve constantly for the community as society changes. While culture influences all persons, there is considerable intra-cultural variation within any culture (Worley, 1997).

## **1.2 Contrast the definitions of ethnicity, race, and culture**

Culture is defined in the previous section as a way of seeing, behaving in and evaluating one's world. Ethnicity refers to identification with a common group linked by race, nationality, language, geography, or familial relations (Worley, 1997). Race is primarily a social classification that relies on physical markers, such as skin color, to identify group membership. The terms culture, ethnicity, and race are used interchangeably in some literature and in common dialogue. It is important to listen or read critically to tell how a speaker or author intends the terms to be used. Individuals may be of the same race but differ in ethnic affiliations. Those who are classified African American may have been born in North America, Africa, or the Caribbean. Although African Americans are heterogeneous they are often viewed as ethnically or racially homogeneous; this may blur the understandings of a culturally diverse group (Degazon, 1996).

For health studies that focus on race or ethnicity the designations for terms may be ambiguous especially when the classifications of study groups fail to consider factors of location, social class, and nationality (Osbourne & Feit, 1992; Krieger et al., 1993). Designation of terms such as Euro-American and white in reports for the south and MDR are also ambiguous because people within these classifications may represent heterogeneous

cultures.

## **1.3 Describe ways to learn the cultural beliefs and practices of a group**

Nurses and community helpers should understand cultures to avoid imposing their own theories of health and decision-making; their own cultures may differ from that of community partners. Appreciation and mutual respect stemming from cultural understanding help parties identify locally expressed health needs, select and focus on priority issues, and negotiate an acceptable approach to address these issues.

While broad generalizations about cultural beliefs and practices, as found in some literature, are useful as a beginning, it is important to learn about local cultures through working with community groups. This is done by keeping an open and objective attitude, being aware of variations among individuals, groups and communities, and reflecting on reasons for behavior. Information about a culture is best taught by persons belonging to that cultural or ethnic group. Such teaching is freely available whenever trust and respect are established and if the work between nurse and the community is seen as worthy and benefitting the community and its representatives.

Guidelines for conducting a cultural assessment are presented by M.M. Andrews and L. Bolin (1993) in the text, Community Health Nursing: Promoting the Health of Aggregates. Also, extensive, advanced guidelines for conducting a cultural or ethnographic study are given by James Spradley (1979) in the classical textbook, The Ethnographic Interview.

Guides given in these and other texts for community health care workers suggest

questions and areas of cultural knowledge that may not be obvious to the student beginning work in a new community. Listening, learning from others, asking to be taught local ways, and being willing to work collaboratively opens the door for learning about a culture. This type of learning is essential in order to respond sensitively to cultural differences.

As noted in Module I, the geographic area of the MDR is large; the cultural characteristics vary across and within states. Cultural patterns for each locality can be learned by nurses as collaboration to improve environmental health is undertaken.

Still, there are cultural factors that are characteristic of the entire MDR; many of these influences are similar for the southern United States as a whole. This module describes southern culture as a whole and by ethnic groups. The history of the south and the MDR figures strongly in the cultural development of Euro-American (white) and African American (black) ethnic groups. This history sets the stage for today's environmental health challenges.

## **Learning Activity**

Search local and state libraries for ethnographic studies of groups residing in the state where you study or practice nursing. After reading one or more of these, share the source with fellow students, workers, and teachers.

Complete the cultural questionnaire for self-assessment. See Appendix A.

Make a detailed list of your activities for one entire day; highlight the behaviors performed daily. What do these activities reveal about your cultural beliefs and practices? Share your

lists with partners or small groups. What cultural perceptions or beliefs do others have about the behaviors and practices on your list?

Make a list of the cultural beliefs and practices that you think a nurse needs to consider and plan for when developing strategies for working with communities on environmental health issues specific or unique to your area.

### **2.1 Describe family and social networks for residents of the Mississippi Delta**

Family, kin, and social networks are strong throughout the Mississippi Delta for both black and white residents. Historically, black and white southerners have relied heavily on close ties with both nuclear and extended families. These close family ties extend beyond the nuclear family to include cousins, aunts, and uncles, all who are "blood" kin. Blood kin (those in consanguineal relationship) are those connected through birth, not through marriage. Historically, children are socialized to think in terms of obligations to parents and others defined as "close kin."

Especially for black families, the stability of the family defined as blood relations and a strong sense of responsibility among members fosters a code of reciprocity. Not all families exhibit an emphasis on consanguineal relationships. Factors such as education, occupational demands, and aspirations toward upward mobility have moved some families toward marriage-focused households where extended families are not defined as "blood" kin. These families are in contrast to a more traditional family where a senior relative, such as the wife's or husband's mother, would have a position of authority in the household equal to or greater than one or both spouses. Among

traditional black families, households are linked together as cooperative units of a larger system, which in turn is part of a broader network of extended kin who pool money and information and who provide emotional support (Dressler, 1985).

For southern families, black and white, social networks provide a wealth of support and assistance. The stress of daily life and threats to health are buffered through rich support experiences in extended families and networks. Such close relations also demand that members return support to others in the group, sometimes obligating members to stay in the geographic area even when tempted by opportunities for work or schooling in other states.

Rural black families throughout the United States are characterized by close ties with the extended family. Native American and white families who reside in the rural southeast have similar familial interaction patterns. Southern rural families are immersed in extended kin relationships, are not prone to move away from their place of birth, maintain frequent interaction with extended kin, and have an attitude of obligation to the family. Kinship interaction is diminished by migration and spatial separation from kin (Lee & Cassidy, 1981). In contrast, rural families in western regions of the United States tend to be cut off geographically from extended kin and stay close to the nuclear family. (Heller et al., 1981).

R. E. Spector (1996) reports that how closely individuals link with family and community networks influences how quickly they turn to the health care system or alternate healers for health problems. Individuals closely linked to social networks tend to look first to leaders in the family and network before seeking help

from outsiders. In such communities seeking medical treatment and risk prevention advice may be delayed. For rural African Americans there is a greater prevalence of two-parent rather than one-parent families. Employment outside the home for the wife is largely dependent on job opportunities in the area. Power is shared equally between parents. Children accept responsibility within a context of acceptance and security, and the elderly are held in high esteem. Often the young and elderly are cared for by the entire community (Hawkes et al., 1981).

Many Americans believe that ethnic and racial identity are important. Anderson (1995) describes race as an “effective category in identity formation.” He states that identity is continually reconstituted as one moves into differentiated social spaces and communities. While racial identity is key for some individuals, ethnic identity produces a more pronounced influence in personality formation for most groups. (MDR population characteristics are presented in Module I..)

## **2.2 Identify health beliefs and practices for groups in the Mississippi Delta Region**

Varied health beliefs for ethnic groups throughout the United States are described in texts on health and culture such as that by Spector (1996). Health beliefs and practices are similar across regions throughout the United States. Folk medicine is widely practiced and has survived over the years (Spector, 1996).

The extent to which traditional beliefs and practices exist in specific geographic locations of the MDR should be explored by the nurse as he or she begins to collaborate with local partners. The following sample of beliefs and

practices are quite general in nature; it is important to validate cultural information with individuals and families to avoid stereotyping.

Spector (1996) concluded that the traditional African American view of health is seen in the context of life; all things whether living or dead are believed to influence each other. Humans have the power to influence their own and others destinies through the use of behavior as well as through knowledge. Being healthy is considered being in harmony with nature, while illness represents a state of disharmony.

Traditional beliefs do not separate the mind, body, and spirit. Disharmony or illness is attributed to a number of sources including evil spirits. Treatment is designed to remove any harmful influences, such as evil spirits, from the sick person. Health is perceived as feeling good, being free of pain, and is classified with other kinds of good luck such as wealth or success.

Andrews and Bolin (1993) report that for African Americans, illnesses are classified as natural or unnatural. Natural illness is thought to occur whenever the person has inadequate protection and is affected by nature's forces, as in catching a cold from exposure to harsh weather. Unnatural illness is caused by evil influences, such as witchcraft, or punishment from God. Such unnatural illness, spiritual in nature, must be cured by a spiritual healer.

Spector presents a discussion on unnatural illnesses and the role of the spiritual healer in the following description of voodoo and its practices. Voodoo is a belief system that was practiced traditionally along the West African coast and spread to the West Indies. It was incorporated into the traditional beliefs in the MDR, particularly in Louisiana. Objects utilized in the practice of voodoo are still for

sale in many southern cities. The extent to which voodoo continues to influence Delta culture today is unclear. Voodoo includes beliefs about health and illness. For example, many illnesses are attributed to a "fix" placed on a person out of anger. Gris-gris, the symbols of voodoo used to prevent illness or give illness to others, include powders and oils in a variety of colors.

Spector (1996) describes health-related religious beliefs and practices for groups in the United States. Spiritual healing through prayer is a method of treating illness for some religious groups. For many in the United States, religion is taken very seriously; healing for illness or troubled relationships is an indication of faith held strongly as a cultural tenet.

Spector (1996) also describes the role of traditional healers, lay persons who are non-academically trained and thought to possess extensive knowledge regarding the use of herbs and roots in the treatment of illness. Examples of these practices include natural herb remedies to restore health, applying turpentine oil liniment to the skin to treat rheumatism, or mustard plasters to the chest to treat severe colds. Traditional healer practice exists among all ethnic groups to some extent (Spector, 1996).

### **2.3 Describe the influence of religion in the southern United States**

Perspectives on the influence of religion in the south comes from (a) the cited literature, (b) the authors' affiliation with religious groups in the south, and (c) the authors' interaction with community residents through churches for the purpose of addressing health concerns.

Christianity is the major religion in the south and

in the MDR. While there are Catholic communities, the region is predominately Protestant. Churches throughout the MDR are centers for spiritual teaching, social organizations giving support to families, and a network for the community through which members are influenced culturally. The church in the south, as well as in the MDR, is an agent for socialization of the young and serves as a testing ground to gain greater understanding of one's experience. Together, members apply their beliefs as they approach daily life and overcome problems (Lincoln & Mamiya, 1990).

Protestant churches affiliate with national and regional organizations that also reflect ethnic connections (Lincoln & Mamiya, 1990). Even though many churches strive for openness and inclusiveness, families tend to select a congregation that reflects both their own ethnic group and socioeconomic status. In rural areas, families tend to continue membership in one congregation over generations. The church may serve as mediator or buffer between individuals and families and the broader community.

Throughout the era of slavery and continuing in the aftermath of the Civil War the black church was change-oriented and increasingly became a source of support and strength. It openly addressed social inequity and became the hub for social change, addressing legal barriers; racial prejudice, and the need for access to health, housing, and employment (Hatch, 1984). In contrast, the plantation church was continuity-oriented (Hill et al., 1972). The modern black church maintains its change orientation. In the MDR, many white churches continue to be continuity-oriented. However, an increasing number of white churches are embracing change. Some churches have been

able to bring together diverse ethnic groups within their membership.

Racism has played an important role in the South and the MDR. The historical forms of racism, struggles for racial justice, and fights against racism through political and social reform are documented by Franklin and Moss (1988) in the well known text, From Slavery to Freedom. Racism is an attitude and behavior that imposes preferential treatment on some and discrimination on others based on one's inherent and learned values. Racism is rooted, in part, in the economic legacy of the plantation system and was reinforced following desegregation in continuing social and economic discrimination.

Racial discrimination continues to influence some groups, including religious groups, as they address social, economic, and environmental concerns. It directly and indirectly limits opportunities for blacks and other minorities in education, health care, employment, and housing. Discrimination is examined as one factor in the study of environmental equity and justice which is addressed in Module V.

In spite of the historical racial difficulties that have plagued some parts of the south, including the MDR, white culture is changing slowly as whites begin to recognize environmental injustice and relate the moral tenets of their religious beliefs to larger community needs. Many southern whites have joined movements to address issues of inequity through community development, social action, and political action. (Anderson, 1995).

### **Learning Activity**

Share stories from the Mississippi Delta Region with fellow students and health care workers in

the community. These stories may be ones that residents shared with you or they may come from your own experiences working and spending time with individuals and families. Include culturally specific factors; such as beliefs and practices related to health, protection, and safety, local customs; and patterns of daily life among community members and outsiders.

Compare stories told and note recurrent cultural themes. How do these cultural themes and practices promote health? How can nurses work with groups within the context of cultural practices and institutions?

Who are the “traditional” healers in the local community? Do they use “chemicals” in their healing practices?

### **3.1 Compare income and education for populations of black and white Americans**

According to 1991 population reports, the African American family income represented 56% of white family income. For African Americans nationwide, unemployment is higher and the percentage of youth completing high school is lower than it is for whites (Andrews & Bolin, 1993). Statistics for 1996 show that the percent of African Americans living in poverty (28.4%) is greater than for whites (11.2%) (U.S. Bureau of the Census, 1997).

Lower socioeconomic status and higher frequency of poverty for blacks stem from a society structured in a way that prevents many blacks from gaining equal access to the social, economic, and political institutions that promote economic advancement and stability (Andrews & Bolin, 1993). Because of economic and social discrimination, people of color

(especially blacks) are disproportionately poor, unemployed or employed in low paying (and often hazardous) jobs.

Poverty is greater for blacks in the MDR than it is for blacks nationally. Income, poverty, and educational attainment statistics for groups in the Mississippi Delta Region are included in Module I.

### **3.2 Describe the relationship between poverty and poor health outcomes**

Population-based research in the past several decades has shown consistently that low socioeconomic status and poor health outcomes are strongly related. However, the relationship of these factors has been difficult to explain even after taking into account important confounding factors such as health habits and access to health care.

Because African Americans and Hispanics in the United States are economically disadvantaged, high rates of some diseases are found in these groups. Attempts to evaluate whether these differences can be explained by socioeconomic differences have been mixed (Guralnik & Leville, 1997; Link & Phelan, 1996). The relationship between race and socioeconomic status may be too complex to unravel using traditional measures of current income and education (Guralnik & Leville, 1997).

A major recurrent stress in the lives of African Americans is the direct and indirect effects of racism. Measurement of racism and its effects on economic stability and health has been largely neglected; medical epidemiology is beginning to address this needed area of research (Krieger et al., 1993).

Allen (1994) examined attitudes about poverty in the United States and describes national policies and programs which effect the poor. Community and national decision-making about providing health care for the poor is powerfully influenced by prevailing attitudes and values that imply or state that the poor could avoid and control their impoverished situation. Universal health care has not been accepted as a means to address national health care inequities. Medicaid, designed to provide health care services to the disabled, low-income and disabled elderly, and low-income families serves fewer than half of poor families (Allen, 1994).

Poverty clearly increases a number of risk factors that contribute to poor health including inadequate nutrition, increased stress, and inability to pay for care. Some behaviors, such as cigarette smoking and working in dangerous environments, also contribute to an increased risk for disease and injury. Poor pregnant women have increased risk for delivery of low-birth-weight babies, which is a strong precursor to neonatal mortality.

Even when health care is available poor families may face condescending manners from health care workers, long waiting hours, transportation challenges, and limited hours of care provision. Because of these factors, health care is often seen by the poor as degrading and humiliating (Spector, 1996).

The federal definition of poverty is used to develop eligibility criteria for entitlement and other government programs such as public housing, Medicaid, aid to families with dependent children, and food stamps. In 1997, the federal poverty level for a family of four was \$16,050 (Institute of Research on Poverty, 1997). Poverty is, however, a relative state;

some groups with a low income may consider themselves wealthy in relationships and life style. For others, poverty may lead to a perception of powerlessness and vulnerability that can adversely affect health (Sebastian, 1996).

## **Learning Activity**

Describe poverty as it is perceived by residents of the community where you study or work. Who do they believe is poor? Where do they live in the community? Is poverty most severe among those who are unemployed or among those who did not complete high school? Is there a relationship between these factors and poverty?

++From your experience in one local community list the contributing factors (precursors) to poverty. Examples include few jobs being available and the high cost of housing. For each precursor you list name two or more elements that could bring it about. These are secondary precursors to the main problem, poverty. For example, lack of industry, stores or other economic enterprises leads to or results in few jobs being available in a community. These contributing factors are secondary precursors to poverty.

List four or five results (effects) from poverty in the same local community for which you analyzed contributing factors. How do these effects impact the health of the community? See Appendix B.

++ Look up the term Brownfields. From EPA and ATSDR offices in your area obtain the listing of local Brownfields sites. How does the Brownfields policy address environmental health? Do you think this policy will have a positive or negative impact on your

community's economic status? What is your role as a nurse advocating for community planning and policy development?

#### **4.1 Discuss the relationship between industry location and economic growth in the MDR to environmental health in the MDR**

Module I describes the economic base for the MDR and delineates many environmental hazards related to increasing industrialization and location of industries discharging toxins within the MDR.

In the mid-1900s manufacturing industries began relocation from metropolitan to nonmetropolitan areas. By 1979, manufacturing had become the largest single employer in rural areas of the United States. This trend was also reflected in the Delta Region of the Mississippi. As industries searched for cheaper land, cheaper labor, and lower taxes, they found conditions favorable in the Delta Region. Most manufacturing jobs were for low-wage workers and workers who had limited opportunities for advancement in manufacturing organizations (Flora, 1992).

When agricultural operations in the MDR became increasingly mechanized, employment for farm laborers became limited. Farm workers who lost low-wage jobs had few alternatives for work; they welcomed industry to the south, hoping for employment.

Following World War II and the collapse of the sugar plantation systems, Louisiana became the prime location for the petrochemical industry. This industry has played an important role in the state economy, covering an 85-mile stretch of the Mississippi River from Baton Rouge to New Orleans. Petrochemical corporations get special tax exemptions from the state of Louisiana. This is one

example of how governments in the region have encouraged big industry into the area (Wright et al, 1994).

In many areas of the MDR, industrial facilities were developed; these industries unfortunately generated toxic emissions along with the desirable commercial products intended. While these industries were considered good for the local economy, they were a burden for communities in which they were located.

As manufacturing or waste processing industries moved into communities a pattern of business development and housing sprang up to support the industry. Often the emerging patterns worked to the disadvantage of poor and low-wage residents. When an industry was sited in a prosperous area, residents of the area would take jobs with the plant and gradually vacate their houses for better housing away from the noise and toxic emissions of the industry. These vacated houses, as they declined in value (due to their proximity to industrial facilities), became more affordable for poor families (Austin & Schill, 1994). Thus poor families frequently gained affordable housing while increasing health risks due to industrial pollution.

#### **4.2 Determine if communities of color have disproportionate risks from environmental pollution**

A number of reports support the observation that poorer neighborhoods bear a disproportionate share of environmental hazards (Northridge & Shepard, 1997). A

study published by the United Church of Christ Commission for Racial Justice (1987) reported that zip code areas containing one hazardous waste site had on the average 24% people of color, compared with 12% in areas without a hazardous waste site. Zip code areas containing either (1) two or more industrial facilities or (2) one of the five largest waste landfills in the nation, had on average 38% people of color.

Sometimes polluting businesses were placed in minority communities following a planning rationale that it “was better to site a hazardous facility in a less densely populated area.” This practice resulted in residents of minority-populated areas experiencing long-term exposures to hazardous conditions (Rogers, 1995).

Hazardous waste sites were at times selected because, it was reasoned, other industries were already in particular communities discharging toxic wastes. This practice created a multitude of risks for groups living close to the selected site. Austin and Schill (1994) state that people of color who are economically impoverished are prime targets for “risky” technologies. They are thought by developers to be more likely to tolerate pollution from commercial development in the hopes that economic benefits will come in the form of jobs, increased tax revenue, and civic improvements. When and if these economic and social benefits are realized, a community may be reluctant to forego them even if accompanied by hazardous spills or emissions (Austin & Schill, 1994).

Differences in lead levels, which are higher among black than white children, are thought to be largely due to housing and other environmental factors. Such exposures are direct consequences of the residential segregation of blacks in old and poor neighborhoods (Northridge & Shepard, 1997).

Ecological and case studies confirm that

communities of color are disproportionately threatened by hazardous and noxious facilities. There is some evidence that the close proximity of hazardous facilities and low-income minority populations is due to the low land values that attract both.

In some communities, minorities do not take full advantage of political processes to influence local decision making and public policy related to environmental risks (Rodgers, 1995). In other communities, jeopardized groups are organizing to address hazardous environmental conditions. Krauss (1994) describes examples in which both black and white working women identified toxic waste issues and utilized kin and friend networks to deal with the problems. Within the MDR there are some organized groups, led by citizens, to address environmental health concerns. See Module VI on how nurses may work with community groups to find solutions promoting better environmental health.

### **Learning Activity**

List the industries located within five miles of your community in the Mississippi Delta Region. What chemicals are used in the industries? Using information about chemicals presented in Module III determine if there are known health risks from the chemicals used.

++Interview a community resident living within two miles of one industry in your community. Use the Interview Guide in Appendix C. Determine the individual’s perception of health risks associated with the industry. Determine the individual’s beliefs about benefits to families and communities from the industry.

## Teaching Methods

Lecture, small group discussion, assigned readings, community field experiences, descriptive data presentation through story telling and cultural self-assessment should be utilized. Development of specific learning activities is suggested for each objective.

## Evaluation

Students may be evaluated for class and group participation, for the performance on selected learning activities, and through examination.

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## **Appendix A: Cultural Assessment Questionnaire for Self Assessment**

Complete the following questions and reflect on the cultural meanings expressed in your answers.

1. To what ethnic, geographic or national group do you belong? You may name more than one.
2. State beliefs you hold about each of the following areas in your life experience.

Maintaining health

Death

Ageing

Spirituality or religion

Body image and change

Food

Work

Education

Fair treatment

Poverty and wealth

Being alone and in groups

Relationships with others of the same sex; of the opposite sex

Parenting

Relations with authorities

Environment

Competition

Expression of strong emotion

3. From whom (according to their role with you) did you learn the values that you hold?



## Appendix B: Causes and Results of Poverty in One Local Community

Direct causes (precursors)

List four direct causes (precursors) to poverty for this local community

1. \_\_\_\_\_  
\_\_\_\_\_

Contributing factors (secondary precursors)

Name two factors that contribute to or result in each of these precursors. These are known as secondary precursors.

\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

Contributing factors (secondary precursors)

\_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

Contributing factors (secondary precursors)

\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_

Contributing factors (secondary precursors)

\_\_\_\_\_

List four results of poverty for the same community.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **Appendix C: Interview Guide for Community Resident About One Industry or Plant in the Neighborhood**

Introduce yourself and the purpose of the requested interview.

(Example of introduction) I am a nurse learning about the community including its industries and some effects they have in the neighborhood, including the physical environment. My purpose is to better understand the community; I am not attempting to remedy possible concerns that are identified. Since you live close to \_\_\_\_\_(Name of Industry or Plant) located in this Community, I would very much like to learn about your ideas. Will you talk with me about it?

### 1. Questions to ask the community resident:

What do you see as benefits to the community and to yourself from the plant located here

Does anything concern or please you about the location of the plant close to your neighborhood?

If you could change one thing about this plant, what would it be?

### 2. Following the interview, consider the following questions:

What actions would you take if you discover a potential health problem during the interview?

What role can nursing take in advocating for the community?

How would your actions be influenced if you knew that even though a local industry poses an environmental threat to the community, closing it would threaten the local economy?

Who are the local policy makers (legislators, council members) and have they expressed interests in environmental health?

